STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445148	A. BUILDING _____ B. WING _____	C 08/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DONELSON PLACE CARE & REHABILITATION CENTER	2733 MCCAMPBELL AVENUE NASHVILLE, TN 37214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility provided records and interview, the facility failed to ensure that one resident (#1) of five residents reviewed, was secured in the transportation van resulting in a fall/laceration from a wheelchair and harm ti resident #1. The findings included: Resident #1 was admitted to the facility on April 15, 2003 with diagnoses including Cellulitis, Hypertension and Muscular Wasting. Medical record review of the Minimum Data Set (MDS) May 12, 2011 revealed the resident had no short or long term memory deficits and the resident was independent in decision making. Further review of the MDS revealed the resident required total assistance with transfers and limited assistance with locomotion on and off of the unit with a wheelchair. Review of documentation provided by the facility dated May 12, 2011 revealed the resident was being transported to two medical appointments by	F 323	Donelson Place Care & Rehabilitation Center ("Facility") does not believe and does not admit that any deficiencies existed, before, during or after the survey. The facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation, or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action of proceedings. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Facility offers its responses as part of its ongoing efforts to provide quality of care to residents. **F 323 483.25 (h) Free of Accident Hazards/Supervision/Devices** **Corrective Action for Residents Affected:** 1. Resident #1 received immediate appropriate medical care at an acute care facility for the superficial injuries sustained on May 12, 2011. 2. On 5/13/11 resident was reassessed by the licensed nurse and care plans updated as appropriate by the IDT team.	8/18/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kerry B. Weir — TITLE: Administrator — (X6) DATE: 8/18/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 323	Continued From page 1 the facility owned transportation van. At a traffic light the driver stopped when the traffic light turned red. The driver heard a noise and turned around to find the resident out of the wheelchair and lying on the floor of the van. The driver pulled over, stopped, walked around and observed the resident's condition. The driver saw blood pooling from the head area onto the floor. The driver phoned the facility and was instructed to proceed to the emergency room. Medical record review of the hospital Trauma History and Physical Report dated May 12, 2011 revealed "...Patient hit the head, has a significant scalp laceration. Of note, patient had a prior craniotomy and is missing skull in the area where the laceration occurred...patient has a large left parietal scalp laceration that is thick and appears to go to brain...We have consulted Neurosurgery to repair the scalp laceration..." Review of documentation provided by the facility dated June 2, 2011 revealed the driver secured the wheelchair to the van at three points not four; did not secure the lap belt correctly, and did not secure the shoulder harness to the resident. Review of the Certified Nurse Assistant (CNA) Transportation Aide #1's statement provided by the facility dated May 13, 2011 revealed "...Upon positioning (resident's) wheelchair in the van, I first put straplets on both back wheels of the wheelchair. I moved (the resident) forward in the wheelchair until the wheels would no longer move. Then I went around to the front of the wheelchair and placed a straplet on the front right wheel which secured it tightly. Upon securing the wheelchair including ensuring wheelchair locks	F 323	3. On 5/16/11 a family and patient meeting was held that included the patient, her daughter, mother and father as well as the facility Administrator, DON, Social Worker and Chaplain. The meeting encouraged the family to verbalize feelings and for the facility stakeholders to inform the family of investigative findings, corrective actions and to express apologies. 4. Corrective action was taken on 5/12/11/by the Administrator who immediately discontinued the facility Van Transportation Program. 5. Alternate transportation was secured by the Social Worker for Resident #1 via Tennessee Carriers, Inc, AMERIGROUP transportation coordinator for appointments on 5/23, 5/25, 6/3 & 6/13 without any incident. **Identification of Residents with potential to be affected** 1. All residents transported via the facility Van were at risk to be affected by the deficient practice. 2. Corrective action was taken immediately on 5/12/11 by the administrator who discontinued transportation via the facility van.	

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F 323	Continued From page 2 were in place (the resident's) wheelchair was very sturdy in place. I then placed a seat belt around the resident reaching from the floor at the back right wheel, threading it through the armrest of the wheelchair right to left reaching the floor of the front left wheel. The seat belt was positioned across the lap and connected to its fastener...After the resident was removed from the van, the wheelchair continue to be sturdy in placed, however the seat belt that I had placed on the resident was still latched but separated at the bracket designed to hold it together..." Further review revealed the shoulder harness was not utilized. Interview with Resident #1 on August 3, 2011 at 1:30 p.m., in the Minimum Data Set (MDS) office, revealed the resident stated the van driver on May 12, 2011 did not correctly use the lap restraint or shoulder harness. Interview with the Director of Nurses (DON) on August 3, 2011 at 3:30 p.m. in the MDS office revealed the van is not in use and had not been in use since May 12, 2011. Further interview revealed the CNA Transportation Aide #1 was terminated from employment for not following safety procedures on May 13, 2011. Interview with the DON on August 3, 2011, at 3:30 p.m., in the MDS office, confirmed the resident was not secured correctly in the transportation van which caused the resident to obtain a laceration to the head resulting in harm to Resident #1.	F 323	**Measures or systems changes to prevent reoccurrence:** 1. The facility Van Transportation Program was immediately discontinued by the Administrator on 5/12/11. 2. Alternate transportation services were secured by the Social Services Director for facility residents through independent transportation companies effective 5/13/11. 3. In-service education was provided for nursing staff on April 13th & 22nd, May 6th and August 16th, 2011 on the facility policy and procedure for Accident and Incidents including falls and equipment use, ensuring resident safety, prevention strategies, and compliance with F-323 regulation. 4. The Social Worker or her designee will conduct a 10% observational audit and interview of residents and families as appropriate of all residents being transported to ensure residents are seated safely prior to transport, for 4 weeks, then 10 % for three months with additional monitoring determined by QA Committee thereafter. 5. IDT team will screen all residents requiring transportation prior to scheduling transportation to determine appropriate mode of transportation and determine if	

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F 323	Continued From page 3 Complaint #TN00028107	F 323	special assistance is required. A tracking form will be utilized to log IDT screenings and special needs of resident's for transfers. **Monitoring changes/systems to ensure no deficient practice:** 1. All resident transportation needs are coordinated through the social service department by the Social Worker or her designee as of 5/13/11 allowing oversight and monitoring of these services. 2. The Social Worker or her designee will conduct a 10% observational audit and interview of residents and families of residents being transported to ensure residents are properly positioned, seated, and secured prior to transport, for 4 weeks, then 10 % for three months with additional monitoring determined by QA Committee thereafter. 3. The results of all audits will be forwarded to the QA Committee monthly for review and recommendations.	